

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025403

Facility Name: CARLTON AT THE LAKE

Address: 725 W. MONTROSE AVE CHICAGO 60613
Number City Zip Code

County: COOK

Telephone Number: (773) 929-1700 Fax # (773) 929-3066

IDPA ID Number: 363075919001

Date of Initial License for Current Owners: 07/31/80

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

X "Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name:: Steve Lavenda Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE

0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>244</u>	Skilled (SNF)	<u>244</u>	<u>89,060</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>244</u>	TOTALS	<u>244</u>	<u>89,060</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>57,656</u>	<u>8,056</u>	<u>3,123</u>	<u>68,835</u>	8
9	SNF/PED					9
10	ICF	<u>13,084</u>	<u>339</u>		<u>13,423</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,740</u>	<u>8,395</u>	<u>3,123</u>	<u>82,258</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.36%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 369 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 8/1/80

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/1//80 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 24 and days of care provided 3,123

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	317,931	115,539	14,909	448,379		448,379	3,702	452,081			1
2	Food Purchase		441,356		441,356	(66,138)	375,218	(449)	374,769			2
3	Housekeeping		63,137	276,857	339,994		339,994	11,819	351,813			3
4	Laundry		44,283	118,653	162,936		162,936		162,936			4
5	Heat and Other Utilities			174,162	174,162		174,162	3,281	177,443			5
6	Maintenance	60,433	25,937	142,902	229,272		229,272	(40,245)	189,027			6
7	Other (specify):*											7
8	TOTAL General Services	378,364	690,252	727,483	1,796,099	(66,138)	1,729,961	(21,892)	1,708,069			8
	B. Health Care and Programs											
9	Medical Director			26,400	26,400		26,400		26,400			9
10	Nursing and Medical Records	2,371,299	264,199	19,451	2,654,949		2,654,949		2,654,949			10
10a	Therapy	111,984		37,590	149,574		149,574		149,574			10a
11	Activities	123,176	45,252	9,895	178,323		178,323		178,323			11
12	Social Services	73,072		6,833	79,905		79,905		79,905			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,679,531	309,451	100,169	3,089,151		3,089,151		3,089,151			16
	C. General Administration											
17	Administrative	446,273		1,605,878	2,052,151		2,052,151	(1,493,326)	558,825			17
18	Directors Fees											18
19	Professional Services			548,869	548,869	(49,412)	499,457	(312,349)	187,108			19
20	Dues, Fees, Subscriptions & Promotions			89,374	89,374		89,374	(45,621)	43,753			20
21	Clerical & General Office Expenses	171,187	894	510,097	682,178		682,178	(277,769)	404,409			21
22	Employee Benefits & Payroll Taxes			492,929	492,929	66,138	559,067		559,067			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,504	1,504		1,504	75	1,579			24
25	Other Admin. Staff Transportation			578	578		578		578			25
26	Insurance-Prop.Liab.Malpractice			256,529	256,529		256,529	806	257,335			26
27	Other (specify):*							53,654	53,654			27
28	TOTAL General Administration	617,460	894	3,505,758	4,124,112	16,726	4,140,838	(2,074,530)	2,066,308			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,675,355	1,000,597	4,333,410	9,009,362	(49,412)	8,959,950	(2,096,422)	6,863,528			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			303,300	303,300		303,300	(100,142)	203,158			30
31	Amortization of Pre-Op. & Org.			13,770	13,770		13,770	17,364	31,134			31
32	Interest			506,016	506,016		506,016	(103,392)	402,624			32
33	Real Estate Taxes			372,063	372,063	49,412	421,475	7,133	428,608			33
34	Rent-Facility & Grounds			1,335,900	1,335,900		1,335,900	(1,335,900)				34
35	Rent-Equipment & Vehicles			43,620	43,620		43,620	(13,264)	30,356			35
36	Other (specify):*											36
37	TOTAL Ownership			2,574,669	2,574,669	49,412	2,624,081	(1,528,201)	1,095,880			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,691	470,474	683,165		683,165		683,165			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,590	133,590		133,590		133,590			42
43	Other (specify):*	22,203			22,203		22,203	(22,203)				43
44	TOTAL Special Cost Centers	22,203	212,691	604,064	838,958		838,958	(22,203)	816,755			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,697,558	1,213,288	7,512,143	12,422,989		12,422,989	(3,646,826)	8,776,163			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(146,677)	30		9
10	Interest and Other Investment Income	(232,250)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(449)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,853)	21		18
19	Entertainment				19
20	Contributions	(33,807)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(419,159)	21		24
25	Fund Raising, Advertising and Promotional	(9,777)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(161,519)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,006,491)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,640,335)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,640,335)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,646,826)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
CARLTON AT THE LAKE		
100	0025403	
Report Period Beginning: 01/01/02		
Ending: 12/31/02		
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	Miscellaneous Income	(302) 21 1
2	Capitalized Repairs & Maintenance	(43,583) 6 2
3	Non-Allowable Legal Fees	(18,676) 19 3
4	COPIE Dues	(2,207) 20 4
5	Non-Allowable Management Fees	(7,000) 19 5
6	Public Relations	(4,029) 20 6
7	Marketing	(2,263) 43 7
8	Bank Charges	(12,870) 21 8
9	Franchise Tax	(74) 21 9
10	Parking Fee Income	(945) 6 10
11	Management Fees - Bernard Cohen & Associates	(12,000) 17 11
12	Carlton Associates - Trust Fees	(260) 21 12
13	Carlton Associates - Accounting	(3,925) 19 13
14	Carlton Associates - State Replacement Tax	(13,411) 21 14
15	Non-Care Depreciation - Auto	(2,490) 20 15
16	Non-Allowable Auto Lease	(17,570) 25 16
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101	Total	(101,519) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARLTON AT THE LAKE

0025403

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			3,702									3,702	1
2	Food Purchase	(449)											(449)	2
3	Housekeeping			11,819									11,819	3
4	Laundry													4
5	Heat and Other Utilities			3,281									3,281	5
6	Maintenance	(44,528)		4,283									(40,245)	6
7	Other (specify):*													7
8	TOTAL General Services	(44,977)		23,085									(21,892)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative	(12,000)			(16,877)	(1,020,979)	(443,470)						(1,493,326)	17
18	Directors Fees													18
19	Professional Services	(29,601)	3,925	(287,917)	984		260						(312,349)	19
20	Fees, Subscriptions & Promotions	(49,820)		491	3,708								(45,621)	20
21	Clerical & General Office Expenses	(448,937)	13,671	154,217	2,439	491	350						(277,769)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			51	24								75	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			806									806	26
27	Other (specify):*			45,807	5,492	2,005	350						53,654	27
28	TOTAL General Administration	(540,358)	17,596	(86,545)	(4,230)	(1,018,483)	(442,510)						(2,074,530)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(585,335)	17,596	(63,460)	(4,230)	(1,018,483)	(442,510)						(2,096,422)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(149,127)	32,185	16,800									(100,142)	30
31	Amortization of Pre-Op. & Org.		16,995	369									17,364	31
32	Interest	(232,250)	107,031	21,827									(103,392)	32
33	Real Estate Taxes			7,133									7,133	33
34	Rent-Facility & Grounds		(1,335,900)										(1,335,900)	34
35	Rent-Equipment & Vehicles	(17,576)		4,312									(13,264)	35
36	Other (specify):*													36
37	TOTAL Ownership	(398,953)	(1,179,689)	50,441									(1,528,201)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(22,203)											(22,203)	43
44	TOTAL Special Cost Centers	(22,203)											(22,203)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,006,491)	(1,162,093)	(13,019)	(4,230)	(1,018,483)	(442,510)						(3,646,826)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Carlton Associates		Building Ptshp.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,335,900	Carlton Associates, Ltd.	100.00%	\$	\$ (1,335,900)	1
2	V	32	Interest Income	268,677	Carlton Associates, Ltd.	100.00%		(268,677)	2
3	V	32	Interest Expense		Carlton Associates, Ltd.	100.00%	375,708	375,708	3
4	V	19	Accounting		Carlton Associates, Ltd.	100.00%	3,925	3,925	4
5	V	21	Trust Fees		Carlton Associates, Ltd.	100.00%	260	260	5
6	V	30	Depreciation		Carlton Associates, Ltd.	100.00%	32,185	32,185	6
7	V	31	Amortization		Carlton Associates, Ltd.	100.00%	16,995	16,995	7
8	V	21	State Replacement Tax		Carlton Associates, Ltd.	100.00%	13,411	13,411	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,604,577			\$ 442,484	\$ * (1,162,093)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	ITEX COMPANY	100.00%	\$ 3,702	\$ 3,702	15
16	V	3	HOUSEKEEPING		ITEX COMPANY		11,819	11,819	16
17	V	5	UTILITIES		ITEX COMPANY		3,281	3,281	17
18	V	6	REPAIRS AND MAINT.		ITEX COMPANY		4,283	4,283	18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY		6,083	6,083	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY		491	491	20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY		23,496	23,496	21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY		51	51	22
23	V	26	INSURANCE		ITEX COMPANY		806	806	23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY		451	451	24
25	V	30	DEPRECIATION		ITEX COMPANY		16,800	16,800	25
26	V	31	AMORTIZATION		ITEX COMPANY		369	369	26
27	V	32	INTEREST		ITEX COMPANY		21,827	21,827	27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY		7,133	7,133	28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY		4,312	4,312	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY		130,721	130,721	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY		45,356	45,356	33
34	V								34
35	V	19	HOME OFFICE	294,000				(294,000)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 294,000			\$ 280,981	\$ * (13,019)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 23,367	\$ 23,367	15
16	V	19	PROFESSIONAL FEES				984	984	16
17	V	20	FEES, SUBSCRIPTIONS				3,708	3,708	17
18	V	21	CLERICAL AND GENERAL				2,439	2,439	18
19	V	24	SEMINARS				24	24	19
20	V	27	GEN ADMIN.- EMP. BEN.				5,492	5,492	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	40,244				(40,244)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 40,244			\$ 36,014	\$ * (4,230)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 42,917	\$ 42,917	15
16	V	21	OFFICE				491	491	16
17	V	27	PAYROLL TAXES				2,005	2,005	17
18	V								18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES				36,296	36,296	21
22	V								22
23	V								23
24	V								24
25	V	21	SECRETARIAL						25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	1,100,192				(1,100,192)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,100,192			\$ 81,709	\$ * (1,018,483)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 6,530	\$ 6,530	15
16	V	19	PROFESSIONAL FEES				260	260	16
17	V	21	OFFICE				350	350	17
18	V	27	PAYROLL TAXES				350	350	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	450,000				(450,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 450,000			\$ 7,490	\$ * (442,510)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Management	20.00%	See Attached	2	3.07%	Shaymark	\$ 6,530	17-07	1
2	Jack Rajchenbach	Relative	Management		See Attached	15	23.07%	Salary	156,111	17-01	2
3	Jack Rajchenbach	Relative	Management		See Attached	15	23.07%	JLR Mgmt	42,917	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 205,558		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization ITEX COMPANY
Street Address 6633 N. LINCOLN AVE.
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 679-9141
Fax Number (847) 679-1820

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	463,355	5	\$ 19,263	\$	89,060	\$ 3,702	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	463,355	5	61,490		89,060	11,819	2
3	5	UTILITIES	AVAILABLE BED DAYS	463,355	5	17,069		89,060	3,281	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	463,355	5	22,282		89,060	4,283	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	463,355	5	31,647		89,060	6,083	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	463,355	5	2,553		89,060	491	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	463,355	5	122,246		89,060	23,496	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	463,355	5	266		89,060	51	8
9	26	INSURANCE	AVAILABLE BED DAYS	463,355	5	4,194		89,060	806	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	463,355	5	2,344		89,060	451	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	463,355	5	87,403		89,060	16,800	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	463,355	5	1,921		89,060	369	12
13	32	INTEREST	AVAILABLE BED DAYS	463,355	5	113,562		89,060	21,827	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	463,355	5	37,112		89,060	7,133	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	463,355	5	22,434		89,060	4,312	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		5	771,563	771,563		130,721	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	267,713			45,356	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,585,062	\$ 771,563		\$ 280,981	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPATH HEALTH NETWORK
Street Address 6633 N LINCOLN AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (888) 707-6700
Fax Number (847) 679-2150

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	617,442	13	\$ 358,512	\$ 358,512	40,244	\$ 23,367	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	617,442	13	15,097		40,244	984	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	617,442	13	56,887		40,244	3,708	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	617,442	13	37,424		40,244	2,439	4
5	24	SEMINARS	CARE PATH FEES	617,442	13	365		40,244	24	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	617,442	13	84,255		40,244	5,492	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 552,540	\$ 358,512		\$ 36,014	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization JLR MANAGEMENT CORP.
Street Address 6633 NORTH LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 679-9141
Fax Number (847) 679-1820

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	59	9	\$ 168,808	\$ 168,808	15	\$ 42,917	1
2	21	OFFICE	AVG. HOURS WORKED	59	9	1,932		15	491	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	59	9	7,887		15	2,005	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296		40	36,296	7
8										8
9										9
10										10
11	21	SECRETARIAL	AVG. HOURS WORKED	40	1	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 219,923	\$ 168,808		\$ 81,709	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SHAYMARK MANAGEMENT CORP.
Street Address 6633 NORTH LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 679-9141
Fax Number (847) 679-1820

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 156,722	\$ 156,722	2	\$ 6,530	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	6,235		2	260	2
3	21	OFFICE	AVG. HOURS WORKED	48	5	8,392	8,392	2	350	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	8,406		2	350	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 179,755	\$ 165,114		\$ 7,490	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐

NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐

NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARLTON AT THE LAKE # 0025403 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	LaSalle National Bank		X	Working Capital			\$	3,413,823		8.77%	\$	276,670	1						
2	First Bank & Trust		X	Auto Loan	\$1,980.00	03/30/01		44,000	3,923			1,638	2						
3	Graybar Financial		X	Nurse Call System	\$3,702.00	12/27/00		150,212	72,665	09/27/04	8.50%	7,828	3						
4	First Priority Leasing		X	Elevator	\$176.00	05/08/02		8,785	9,152	04/28/07		271	4						
5	LaSalle National Bank		X	MortgagePayable				2,630,663				375,708	5						
	Working Capital																		
6	Shareholders	X						550,000	550,000		P + 2%	61,770	6						
7													7						
8													8						
9	TOTAL Facility Related				\$5,858.00		\$	752,997	\$	6,680,226		\$	723,885	9					
	B. Non-Facility Related*																		
10	See Supplemental Schedule											(321,971)	10						
11	Insurance Financing		X									710	11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$		\$			(321,261)	14						
15	TOTALS (line 9+line14)						\$	752,997	\$	6,680,226		\$	402,624	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
1	Allocation Itex	X					\$					\$	21,827	1
2	Interest Income		X										(232,250)	2
3	Mortgage Prepayment Penalty		X										157,129	3
4	Interest Income-Carlton Assoc.	X											(268,677)	4
5														5
6														6
7														7
8														8
9														9
10														10
11														11
12														12
13														13
14														14
15														15
16														16
17														17
18														18
19														19
20														20
21							\$		\$			\$	(321,971)	21

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CARLTON AT THE LAKE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0025403

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	14-16-300-003-0000	Nursing Home	\$ 87,643.42	\$ 87,643.42
2.	14-16-300-004-0000	Nursing Home	\$ 89,980.17	\$ 89,980.17
3.	14-16-300-005-0000	Nursing Home	\$ 85,332.51	\$ 85,332.51
4.	14-16-300-006-0000	Nursing Home	\$ 87,643.42	\$ 87,643.42
5.	14-16-300-007-0000	Nursing Home	\$ 703.05	\$ 703.05
6.	14-16-300-008-0000	Nursing Home	\$ 11,114.32	\$ 11,114.32
7.	10-35-312-022	Home Office	\$ 39,312.21	\$ 7,223.61
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 401,729.10	\$ 369,640.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CARLTON AT THE LAKE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0025403

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

Four

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

34,219

2. Number of Years Over Which it is Being Amortized:

5

3. Current Period Amortization:

31,134

4. Dates Incurred:

2002

Nature of Costs:

Loan costs = \$13,770; Allocation Itex \$369; Carlton Associates \$16,995

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1993	\$ 153,000	1
2					2
3	TOTALS			\$ 153,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		105,427		20	3,999	3,999	101,530	9
10	Various		1981		5,718		20	-		5,718	10
11	Various		1982		2,618		20	-		2,618	11
12	Various		1983		19,855		20	48	48	19,599	12
13	Various		1984		34,158		20	-		34,155	13
14	Various		1985		72,850		20	112	112	72,665	14
15	Various		1986		24,885		20	1,251	1,251	20,765	15
16	Various		1988		6,456		20	141	141	5,641	16
17	Various		1989		61,761		20	3,223	3,223	42,549	17
18	Various		1990		71,334		20	3,567	3,567	44,758	18
19	Various		1991		165,717		20	8,286	8,286	83,976	19
20	Various		1992		228,201		20	11,541	11,541	131,014	20
21	Various		1993		40,886		20	2,986	2,986	29,216	21
22	Various		1994		51,259		20	3,063	3,063	25,571	22
23	Various		1995		92,308		20	4,616	4,616	35,891	23
24	Various		1996		58,573		20	3,180	3,180	20,832	24
25	Various		1997		204,822		20	10,242	10,242	74,184	25
26	Various		1998		26,362		20	1,319	1,319	6,460	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,633,555	41,417		44,497	3,080	416,735	68
69	Financial Statement Depreciation			151,480			(151,480)		69
70	TOTAL (lines 4 thru 69)		\$ 2,906,745	\$ 192,897		\$ 102,071	\$ (90,826)	\$ 1,173,877	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,906,745	\$ 192,897		\$ 102,071	\$ (90,826)	\$ 1,173,877	1
2	FIRE DOORS	1999	5,604		20	280	280	1,050	2
3	FIRE DOORS	1999	5,110		20	256	256	896	3
4	TELESCOPING CHUTE	1999	3,350		20	168	168	588	4
5	AIR CLEANER	1999	1,300		20	65	65	255	5
6	EXIT SIGN	1999	1,033		20	52	52	178	6
7	CEILING TILES	1999	1,566		20	78	78	267	7
8	SOFFIT	1999	932		20	47	47	157	8
9	CONDENSER	1999	2,063		20	103	103	343	9
10	EXIT SIGNS	1999	781		20	39	39	127	10
11	HOT WATER VALVE	1999	2,165		20	108	108	342	11
12	DRAIN LINE	1999	1,365		20	68	68	215	12
13	SPRINKLERS	1999	769		20	38	38	136	13
14	PIPE	1999	965		20	48	48	172	14
15	ELEVATOR IMPROVEMENT	2000	8,174		20	409	409	1,091	15
16	AMC ELECTRIC	2000	3,500		20	175	175	496	16
17	AMC ELECTRIC	2000	2,935		20	147	147	404	17
18	WINDOWS	2000	9,570		20	479	479	1,317	18
19	WINDOWS	2000	3,207		20	160	160	440	19
20	DOORS	2000	1,085		20	54	54	140	20
21	DOORS	2000	1,972		20	99	99	256	21
22	120 VOLT CIRCUITS	2000	1,556		20	78	78	195	22
23	EXHAUST FAN	2000	9,950		20	498	498	1,204	23
24	EXHAUST FAN	2000	1,513		20	76	76	184	24
25	EXHAUST FAN	2000	4,337		20	217	217	524	25
26	PIPING INSULATION	2000	5,608		20	280	280	723	26
27	165 WALL OUTLETS	2000	16,500		20	825	825	1,925	27
28	55 NEW TV OUTLETS	2000	5,500		20	275	275	642	28
29	HOT WATER PUMP	2000	825		20	41	41	165	29
30	NEW MOTOR	2000	1,610		20	81	81	310	30
31	HEAT CIRCULATING PMP	2000	1,125		20	56	56	225	31
32	NURSE STATION/CLOSET	2000	132,000		20	6,600	6,600	20,900	32
33	FLOURESCENT FIXTURES	2000	6,370		20	319	319	850	33
34	TOTAL (lines 1 thru 33)		\$ 3,151,085	\$ 192,897		\$ 114,290	\$ (78,607)	\$ 1,210,594	34

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,597,603	\$ 192,897		\$ 136,471	\$ (56,426)	\$ 1,253,055	1
2	ELEVATOR REPAIR	2002	1,738		20	87	87	87	2
3	ELEVATOR REPAIR	2002	693		20	35	35	35	3
4	ELEVATOR REPAIR	2002	697		20	36	36	36	4
5	ELEVATOR REPAIR	2002	965		20	48	48	48	5
6	ELEVATOR VALVE REPLACEMENT	2002	9,369		20	468	468	468	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$3,611,065	\$192,897		\$137,145	\$(55,752)	\$1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,611,065	\$192,897		\$137,145	\$(55,752)	\$1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,065	\$ 192,897		\$ 137,145	\$ (55,752)	\$ 1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$3,611,065	\$192,897		\$137,145	\$(55,752)	\$1,253,729	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,611,065	\$192,897		\$137,145	\$(55,752)	\$1,253,729	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1993		\$1,255,206	\$32,185	39	\$32,185	\$904	\$301,734	4
5			1993		308,310	7,905	35	8,809		84,417	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - Itex/A.K. Care			1993	38,794	468	20	1,940	1,472	18,827	9
10				1994	20,837	542		1,042	500	8,628	10
11				1995	3,551	129		178	49	1,278	11
12				1996	201	17		10	7	71	12
13				1997	5,991	154		300	146	1,647	13
14				1999	665	17		33	16	133	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,633,555	\$41,417		\$44,497	\$3,094	\$416,735	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$618,415	\$128,272	\$56,624	\$(71,648)	10	\$323,854	71
72	Current Year Purchases	67,093	26,216	6,889	(19,327)	10	6,889	72
73	Fully Depreciated Assets	544,293				10	544,292	73
74								74
75	TOTALS	\$1,229,801	\$154,488	\$63,513	\$(90,975)		\$875,035	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	1989	\$17,834	\$	\$	\$	5	\$17,834	76
77		CADILLAC 2001	2001	25,000	2,450	2,500	50	5	4,792	77
78										78
79										79
80	TOTALS			\$42,834	\$2,450	\$2,500	\$50		\$22,626	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,036,700	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$349,835	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$203,158	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(146,677)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,151,390	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CADILAC 2001 - 1900	\$24,000	\$2,450	\$3,949	86
87					87
88					88
89					89
90					90
91	TOTALS	\$24,000	\$2,450	\$3,949	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 30,356 Description: Postage Meter \$2409; Copier 23,555; Oxygen Concentrator \$80; Itex \$4312
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lincoln Towncar	\$ 524.00	\$ 6,289	17
18	Facility	Cadillac	789.00	8,679	18
19	Facility	2003 Cadillac	838.00	2,608	19
20	Page 5 Adjustment			(17,576)	20
21	TOTAL		\$ #####	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility							
		Drop-outs	Completed	Contract	Total				
1	Community College Tuition	\$	\$	\$	\$				
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$	\$	\$	\$				
10	SUM OF line 9, col. 1 and 2 (e)	\$							

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 200,887	\$		\$ 200,887	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			29,587			29,587	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			240,000			240,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				169,377		169,377	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						43,314		43,314	13
14	TOTAL			\$		\$ 470,474	\$ 212,691		\$ 683,165	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 622	\$ 431,012	1
2	Cash-Patient Deposits	144,351	144,351	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,872,315	2,872,315	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	184,475	184,475	6
7	Other Prepaid Expenses	8,837	8,837	7
8	Accounts Receivable (owners or related parties)	4,298,082	5,487,877	8
9	Other(specify): See Supplemental Schedule	7,453	7,453	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,516,135	\$ 9,136,320	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		153,000	13
14	Buildings, at Historical Cost		1,255,206	14
15	Leasehold Improvements, at Historical Cost	1,053,542	1,053,542	15
16	Equipment, at Historical Cost	1,725,562	1,847,562	16
17	Accumulated Depreciation (book methods)	(1,916,023)	(2,339,757)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	34,219	100,320	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,703)	(5,703)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	497,859	497,859	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,389,456	\$ 2,562,029	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,905,591	\$ 11,698,349	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,221,225	\$ 1,221,227	26
27	Officer's Accounts Payable	10,580	10,580	27
28	Accounts Payable-Patient Deposits	147,624	147,624	28
29	Short-Term Notes Payable	658,389	658,389	29
30	Accrued Salaries Payable	206,119	206,119	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,017	20,017	31
32	Accrued Real Estate Taxes(Sch.IX-B)	380,538	380,538	32
33	Accrued Interest Payable	(685)	(685)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	9,865	9,865	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,653,672	\$ 2,653,674	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,391,174	3,391,174	39
40	Mortgage Payable		2,630,663	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,391,174	\$ 6,021,837	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,044,846	\$ 8,675,511	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,860,745	\$ 3,022,838	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,905,591	\$ 11,698,349	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,209,736	1
2	Restatements (describe):		2
3	Prior Year Depreciation	55,557	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,265,293	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(404,548)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (404,548)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,860,745	24

*

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **CARLTON AT THE LAKE**

0025403

Report Period Beginning: **01/01/02**

Ending: **12/31/02**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,070,554	1
2	Discounts and Allowances for all Levels	(665,424)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,405,130	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	877,803	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 877,803	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	205	15
16	Rental of Facility Space		16
17	Sale of Drugs	268,684	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,611	19
20	Radiology and X-Ray		20
21	Other Medical Services	104,389	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 379,889	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	232,250	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 232,250	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	123,369	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 123,369	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,018,441	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,796,099	31
32	Health Care	3,089,151	32
33	General Administration	4,124,112	33
	B. Capital Expense		
34	Ownership	2,574,669	34
	C. Ancillary Expense		
35	Special Cost Centers	705,368	35
36	Provider Participation Fee	133,590	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,422,989	40
41	Income before Income Taxes (line 30 minus line 40)**	(404,548)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (404,548)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CARLTON AT THE LAKE

0025403

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,856	2,073	\$ 84,991	\$ 41.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,143	46,869	978,478	20.88	3
4	Licensed Practical Nurses	19,064	24,204	380,154	15.71	4
5	Nurse Aides & Orderlies	76,351	94,637	775,506	8.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,301	11,788	111,984	9.50	8
9	Activity Director	1,938	2,125	30,875	14.53	9
10	Activity Assistants	9,768	10,537	92,301	8.76	10
11	Social Service Workers	5,276	6,477	73,072	11.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,095	2,379	38,055	16.00	14
15	Cook Helpers/Assistants	35,415	37,567	279,876	7.45	15
16	Dishwashers					16
17	Maintenance Workers	3,775	4,774	60,433	12.66	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,066	2,199	237,609	108.05	20
21	Assistant Administrator	2,054	2,115	52,553	24.85	21
22	Other Administrative	2,087	2,109	156,111	74.02	22
23	Office Manager					23
24	Clerical	8,023	8,376	171,187	20.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,978	12,135	152,170	12.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,193	2,301	22,203	9.65	33
34	TOTAL (lines 1 - 33)	225,383	272,665	\$ 3,697,558 *	\$ 13.56	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 14,909	01-03	35
36	Medical Director	Monthly	26,400	09-03	36
37	Medical Records Consultant	Monthly	4,394	10-03	37
38	Nurse Consultant	106	2,663	10-03	38
39	Pharmacist Consultant	Monthly	4,594	10-03	39
40	Physical Therapy Consultant	268	14,104	10a-03	40
41	Occupational Therapy Consultant	384	23,486	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	158	9,895	11-03	44
45	Social Service Consultant	73	6,833	12-03	45
46	Other(specify)				46
47	Dental	Monthly	4,200	10-03	47
48	Utilization Review		3,600	10-03	48
49	TOTAL (lines 35 - 48)	989	\$ 115,078		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Rosemary Betz	Administrator	0	\$ 237,609	Workers' Compensation Insurance		\$ 42,290	IDPH License Fee	\$	
Bila Ciceki	Asst Admin	0	31,726	Unemployment Compensation Insurance		27,411	Advertising: Employee Recruitment	25,749	
Christopher Betz	Asst Admin	0	20,827	FICA Taxes		266,889	Health Care Worker Background Check	2,410	
Jack Rajchenbach	Executive Dir	0	156,111	Employee Health Insurance		116,437	(Indicate # of checks performed 241)		
				Employee Meals		66,138	Advertising	9,777	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	9,331	
				Head Tax		5,420	Licenses	2,064	
				Pension		23,271	Public Relations	4,029	
				Christmas Expense		11,211	Allocation Itex	491	
							Allocation Carepath	3,708	
							Less: Public Relations Expense	(4,029)	
							Non-allowable advertising	(9,777)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 446,273		\$ 43,753	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		CARLTON AT THE LAKE		STATE OF ILLINOIS				Page 23
		#	0025403	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
IL Council on LTC \$12,934

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 28,865 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 133,590

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?
Indicate the amount.

\$ 66,138
N/A

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
No
N/A
N/A
Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT